An Accident and Medical Clinic
Registered Nurse, RN C

A Report by the

Health and Disability Commissioner

(Case 13HDC01568)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 8 November 2013, 72-year-old Mrs A had spinal surgery at a private hospital. Mrs A's surgery was completed without complications and, on 10 November 2013, she was discharged.

2. Just before 8.00pm on 12 November 2013, while Mrs A was at home, she vomited a large amount of blood. Mrs A's daughter, Ms B, took Mrs A to an accident and medical clinic (the clinic), arriving between 8.00pm and 8.30pm.

3. Ms B told the receptionist, Ms D, that her mother had recently undergone spinal surgery and was vomiting up blood. Having overheard Ms B, registered nurse (RN) Ms C told Ms B to call an ambulance for her mother to be taken to hospital. RN C considered that Mrs A required hospital treatment, and that a personal call would achieve a priority response from the ambulance service, rather than if the clinic contacted the ambulance for her. RN C did not triage Mrs A, take a history, or undertake an initial assessment of Mrs A. Ms B immediately telephoned 111 on her cell phone from inside the clinic building. Mrs A waited for the ambulance with her daughter, while lying down in the back of Ms B's car in the clinic car park.

4. At 8.42pm an ambulance arrived and Mrs A was taken to a public hospital, where she was diagnosed with multiple stomach ulcers.

5. RN C failed to assess Mrs A when she presented to the clinic, failed to contact the ambulance service, and failed to offer any assistance to Mrs A while waiting for the ambulance, including monitoring her. Accordingly, RN C failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights 1996 (the Code).[1]

6. Adverse comment was made with regard to RN C's subsequent inability to provide handover to the ambulance service.

7. The clinic took steps that were reasonably practicable to prevent acts or omissions such as RN C's in this event. The clinic was not directly or vicariously liable for RN C's breaches of the Code.

Complaint and investigation

8. The Commissioner received a complaint from Ms B about the services provided to her mother, Mrs A, by registered nurse RN C, at an accident and medical clinic. The following issues were identified for investigation:

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

- *Whether the clinic provided an appropriate standard of care to Mrs A in November 2013.*
- *Whether Registered Nurse RN C provided an appropriate standard of care to Mrs A on 12 November 2013.*

9. An investigation was commenced on 24 March 2014. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant
Accident and Medical Clinic	Provider
RN C	Registered nurse
Ms D	Receptionist

10. Information was also reviewed from:

District health board	Provider
Private hospital	Provider

11. Independent expert advice was obtained from the Commissioner's in-house nursing advisor, Registered Nurse Ms Dawn Carey (**Appendix A**).

Information gathered during investigation

Mrs A — spinal surgery

12. On 8 November 2013, 72-year-old Mrs A had spinal surgery at a private hospital. Mrs A's surgery was completed without complications and, on 10 November 2013, she was discharged.

13. Just before 8.00pm on 12 November 2013, while Mrs A was at home, she vomited a large amount of blood. Mrs A's daughter, Ms B,[2] telephoned the private hospital and was advised either to call 111 or take Mrs A to the nearest emergency clinic. Ms B took Mrs A to the clinic as it was close to her home.

Care provided at the clinic

14. The clinic is a 24-hour, seven days a week service that provides after-hours accident, medical and specialist services.

15. Between 8.00pm and 8.30pm on 12 November 2013, Mrs A arrived at the clinic with Ms B. Ms B told the receptionist, Ms D, that her mother had recently undergone spinal surgery and was vomiting blood.

[2] As Mrs A does not speak English, Ms B's recollection of events represents both hers and her mother's.

16. Ms B advised HDC that immediately after she explained her mother's condition to Ms D, a registered nurse (later identified as RN C[3]) said loudly across the reception area: "No we cannot do anything about it if it is involving blood." RN C then asked Ms B whether her mother had New Zealand residency, to which she responded that she did.[4] Ms B told HDC that she "sensed some racism" in how she and her mother were treated in being asked about her mother's residency status.

17. According to Ms B, RN C then told her: "You will have to call emergency yourself." Ms B said that when she questioned why the clinic could not look at her mother, RN C repeated that they could not look at her "if it [was] involving blood". RN C further told Ms B that she would be charged if the clinic had to call an ambulance for her mother. According to Ms B, RN C then asked her to call 111 from outside the building. Ms B told HDC that no assistance was offered by staff at the clinic.

18. In contrast to Ms B's recollection, Ms D advised HDC that RN C overheard Ms B describing her mother's condition to Ms D and explained to Ms B that there would be a long wait time at the clinic, and that her mother would probably be sent to hospital anyway, so it "was up to her whether she stayed here or called an ambulance". Ms D told HDC that she believed RN C spoke to Ms B "in a very kind and caring [way], ensuring [Mrs A] felt looked after". Ms D said that she recalls RN C explaining to Ms B that, in order for someone at the clinic to call the ambulance for her, she would have to put her mother into the system, and that Ms B "could call the ambulance privately from outside the front of the building". Ms D said that Ms B appeared confused, and that she wanted the ambulance contacted immediately.

19. Ms B told HDC that, as she did not want to waste any time, she immediately telephoned 111 on her cell phone from inside the clinic building. Ms B said that, as her mother had just had a spinal operation, she waited for the ambulance while lying down in the back of the car, in the clinic car park.

20. It is recorded in the ambulance service's patient report form that an ambulance was dispatched at 8.31pm. At 8.42pm an ambulance arrived at the clinic. Ms D told HDC that ambulance staff came into the clinic building looking for a patient. She said that she recalls being confused, as there were no patients in the building requiring an ambulance at that time. She told HDC: "We were all confused about who called the ambulance. I had assumed that [Ms B and Mrs A] had gone to the hospital already."

21. Mrs A was eventually located by ambulance staff and taken to a public hospital, where she was diagnosed with multiple stomach ulcers.

[3] The clinic confirmed that RN C is seen on CCTV footage as being the registered nurse who presented at the counter and spoke to Ms B. Ms D also confirmed that RN C was the nurse who spoke to Ms B on the evening of 12 November 2013.

[4] Ms B told HDC that her mother has had New Zealand residency for 20 years, and that this information would have been available to the clinic in the computer system.

RN C's response to the complaint

22. RN C advised HDC that she does not have any recollection of the events of 12 November 2013, but accepts that she was working on that evening, and that she was the registered nurse who spoke to Mrs A and Ms B. RN C advised HDC:

> "[W]hile it was certainly not my practice to advise patients presenting to the clinic to call an ambulance, in the heat of the moment I may have done so on this occasion. At that moment I expect I weighed up the best option given the number of patients already waiting to be seen in the clinic, the time available for triaging, the time it would take for Mrs A to be seen by one of our doctors, and the inevitable transfer to hospital by ambulance, and suggested that [Ms B] call 111.
>
> I accept that was a mistake on my part. We do not ever turn patients away …"

23. RN C further told HDC:

> "I accept that I should have triaged and formally transferred [Mrs A], which would have included calling the ambulance service, but I am sure my thinking was impacted by two things:
>
> 1. that because [Mrs A] complained of post-operative vomiting of blood, resources available at [the private hospital] would be required that were not available at [the clinic]; and
>
> 2. my prior experience that a patient calling [the ambulance service] would achieve a priority response, [which] would get [Mrs A] to hospital sooner than if she was triaged and then formally transferred from [the clinic] …"

24. In support of her statement that a phone call request for an ambulance from a patient would receive a priority response over a phone call from a medical centre, RN C provided HDC with an email from the ambulance service's manager, dated 26 August 2014, which set out the following:

> "… [I] can confirm to you that generally speaking for any given complaint with the same acuity a patient in the community would be prioritised over a patient at a medical facility.
>
> For example if a patient with asthma speaking 3 words per breath was in the community and a patient with the same acuity was at a medical facility and both were requiring an ambulance then the community patient would get the ambulance first."

25. Despite what is set out above, RN C does not accept that she asked Ms B to call the ambulance from outside the clinic building, and advised that "[t]here was obviously a very unfortunate breakdown in communication here".

26. With regard to having asked Mrs A about her residency status, RN C advised that she would have requested this information because transfer of non-residents by ambulance can cost "upwards of $660". RN C stated:

> "I assure [Ms B] that any interaction I had with her was not in any way motivated by her ethnicity. It is important that patients are aware of potential charges, and I made no assumption as to whether [Mrs A] was a New Zealand citizen or not …"

27. The clinic confirmed that staff always ask patients about their residency status so that they are aware of any additional cost they might incur, and stated that there was no intention of racial discrimination.

28. Overall, RN C expressed regret for what occurred on 12 November 2013. She advised HDC as follows:

> "I understand this whole experience must have been very upsetting for [Mrs A] and her daughter and family. I deeply apologise for the inconvenience and distress arising from my involvement on 12 November."

Clinic policies relevant at the time of the events in question

29. The clinic's "Triage Management" policy dated 2012 states:

> "Every patient is triaged on arrival to the clinic by an appropriately skilled health care professional. Triage involves a clinical decision based on the individual needs for care.
>
> …
>
> Any patient presenting to the front desk in obvious distress (e.g. severe shortness of Breath, severe bleeding) the receptionist should notify the nurse or duty doctor immediately and bring the patient around to the triage area."

30. The clinic's "Ambulance Transfer" policy dated 2012 states:

> "It is the responsibility of the registered nurse to document all patient transfers to other Health service providers in the **Ambulance Transfer Book** located at the Nurses station.
>
> …
>
> **Patients Requiring an ambulance for transfer from the clinic:** This is the responsibility of the Medical/Nursing staff on duty to request an ambulance. In certain circumstances this responsibility may be delegated to the receptionist.
>
> …
>
> Medical patients being transferred to hospital must be made aware that they will be invoiced by the ambulance service.
>
> A hand over by the Medical staff and patient documentation is required to be given to the ambulance staff receiving the patient transfer.

Management of patients awaiting transfer

A patient awaiting transfer to hospital is kept under constant clinical observation by medical staff, depending on the patient's clinical status, until the ambulance arrives.

Unstable patients should never be left alone …

Ongoing documentation of the patient's vital signs and review records to take place as per usual good clinical practice.

…

The duty-doctor and duty-nurse remain responsible for the patient's care until the patient has been handed over to [ambulance service] staff.

Where it is practically possible, and definitely in all unstable patients, the Duty Nurse or Duty Doctor should accompany the patient outside until the ambulance physically leaves the premises."

Response from the clinic

31. The clinic told HDC that normal procedure if a patient is deemed to be outside the scope of the clinic's services is to "stabilise and then transfer by ambulance to hospital". The clinic acknowledged that "[t]his procedure was not followed in this case".

32. The clinic stated that it "acknowledged that an appropriate standard of care for [Mrs A] was not provided" in these circumstances, and "unreservedly" apologised for this. The clinic advised HDC that it does not consider the actions taken by RN C on 12 November 2013 to be "indicative of [her] usual standard of competence or performance as a nurse". The clinic stated that it considers that RN C has learned from this event and is "unlikely to repeat such an error in the future".

33. The clinic has undertaken an internal review and assessment with respect to the matters relating to this complaint. The clinic stated that the review showed that:

"policies and procedures for management of such presentations were appropriate, but not followed in this instance by an otherwise competent and respected senior nurse …"

Updated policies

34. The clinic advised HDC that, irrespective of the fact that it believes its policies and procedures in place at the time of these events were appropriate, it has now implemented the following additional policies, in light of the incident with Mrs A.

35. The updated clinic "Patient Presentations" policy states that the purpose of the policy is:

> "[t]o ensure that patients who present at the clinic are booked into Medtech and assessed by Medical Staff with accurate notes recorded prior to being either processed through the clinic or transferred through to another facility".

36. The policy confirms that all patients who present at the clinic "must be booked into Medtech …" before then being triaged by the duty nurse or duty doctor.

37. The new clinic "Scope of Practice" policy states the following:

> "1. [The clinic] is a level 2 Accident and Medical Clinic that provides Accident and Medical Care within well-defined clinical boundaries to its surrounding community.
>
> 2. Given that the clinic is an A&M Clinic only with no patient database, those conditions that fall outside the boundaries of the clinics Scope of Practice are managed with the Best Practice Principles of Accepted Accident and Medical Care and then on-referred to the appropriate Branch of Medicine for continuity of care.
>
> 3. By way of an example:
>
> …
>
> urgent or emergency cases whilst being stabilised … are referred to and best managed in a tertiary centre for definitive specialist care."

38. The new clinic "Hypovolaemic Shock from Uncontrolled Bleeding" policy outlines steps to be taken by "[a]ll staff who come into contact with blood or bodily fluid" including the following:

> "… Organise Ambulance Priority 1 to transport patient direct to a major hospital whenever feasible, providing as much pre-hospital warning as possible.
>
> …
>
> The most important aspects of pre-hospital care are to stop external bleeding and organise rapid transport to an appropriate hospital …"

Responses to the provisional opinion

The clinic

39. In response to the provisional opinion the clinic told HDC:

> "…[RN C] has become one of our most senior and capable nurses. Her usual standards of conduct, professionalism and skill are high.[5] As such, we were surprised by [RN C's] error in this case. It is an entirely isolated incident that is entirely out of character for [RN C] and her usual standards of practice.
>
> …

[5] In this respect, RN C submitted copies of her performance appraisals between 2007 and 2013 which support this view.

> We acknowledge it was a significant failure on [RN C's] part; however it is the only such event on an otherwise spotless record and a mistake we do not believe will be repeated."

RN C

40. In response to the provisional opinion RN C told HDC that she:

> "accepts that [Mrs A] should have been entered into the system at the clinic, triaged, assessed and managed from there. But all of these steps would have taken time."

In light of her statement that Ms B was advised to call an ambulance for Mrs A personally in order to facilitate a priority response from the ambulance service, RN C submitted:

> "…The fact the expected outcome in terms of the prompt arrival of the ambulance service and assessment of [Mrs A] is what actually happened, provides important context in this case."

41. RN C told HDC that she is willing to undergo training or a competence review with regard to the issues raised in Mrs A's complaint.

Opinion: RN C

42. On 12 November 2013 Mrs A arrived at the clinic with her daughter, Ms B, who explained to the receptionist that Mrs A had recently undergone spinal surgery and had been vomiting blood. Having overheard Ms B's explanation of her mother's condition, RN C told Ms B to call an ambulance for her mother to be taken to the hospital.

43. RN C advised HDC that she believes that her advice in this regard would have been on the basis that, given Mrs A's presentation regarding postoperative vomiting of blood, she would inevitably require hospital treatment, and it was faster to contact 111 immediately, rather than processing Mrs A through the clinic's system.

44. Overall, I am of the view that RN C provided poor care to Mrs A. RN C did not provide services to Mrs A with reasonable care and skill. I accept the advice of my nursing expert, RN Dawn Carey, that the departures from expected standards were severe. My specific comments regarding the care provided by RN C are as follows.

Failure to undertake initial assessment of Mrs A — Breach

45. The clinic's "Triage Management" policy dated 2012 addresses what should occur when a patient presents at the clinic. In particular it states:

> "Every patient is triaged on arrival to the clinic by an appropriately skilled health care professional. Triage involves a clinical decision based on the individual needs for care."

46. The policy further states that any patient presenting to the front desk in "obvious distress, (e.g … severe bleeding)" should immediately be taken to the "triage area" to be processed appropriately by a registered nurse or duty doctor.

47. RN C failed to triage Mrs A, and did not take a history or undertake an initial assessment of Mrs A, including checking her vital signs. RN Carey was critical of RN C's failure to assess Mrs A. She advised:

> "In my opinion the evaluation of such a symptom [as bleeding] and its effect on a patient's haemodynamic[6] status requires the checking of vital signs. I am critical that this was not done."

48. RN Carey further stated that "[a]ccurate assessment and evaluation of clinical findings are integral parts of the nursing process".

49. I am severely critical that RN C failed to assess Mrs A when she presented at the clinic on 12 November 2013 with postoperative vomiting of blood, requiring hospital care. For this failure, I find that RN C failed to provide services to Mrs A with reasonable care and skill and, accordingly, RN C breached Right 4(1) of the Code.

Failure to facilitate a safe transfer — Breach

50. Mrs A presented to the clinic as an elderly woman experiencing symptoms of postoperative vomiting of blood, requiring hospital level care. RN C did not assess Mrs A. Instead, RN C told Ms B to telephone 111 and request an ambulance to take her mother to hospital, as RN C considered that a personal telephone call would receive a priority response over a telephone call from the clinic. Ms B telephoned 111 from inside the building and then she waited in the car park for the ambulance with her mother, who lay down in the back of Ms B's car (Mrs A was unable to sit in the waiting room because of her recent spinal surgery).

51. RN C told HDC that she suggested Ms B telephone 111, rather than the clinic contacting an ambulance for her, because Mrs A would inevitably require hospital treatment, and a telephone call directly from the patient would achieve a priority response from the ambulance service. The ambulance service confirmed to the clinic that where two patients are presenting with the same acuity, a patient in the community would be prioritised over a patient in a medical facility. RN C further submitted that:

> "…The fact the expected outcome in terms of the prompt arrival of the ambulance service and assessment of [Mrs A] is what actually happened, provides important context in this case."

[6] Blood flow or circulation.

52. Irrespective of what is set out above, I remain of the view that RN C's instruction to Ms B to call an ambulance herself, and RN C's failure to offer further assistance, including monitoring of Mrs A while waiting for the ambulance, was not appropriate in the circumstances.

53. As outlined above, the Ambulance Transfer policy at the clinic provides that it is "the responsibility of the Medical/Nursing staff on duty to request an ambulance". The Ambulance Transfer policy also states that a patient awaiting transfer to hospital should be kept under "constant clinical observation by medical staff, depending on the patient's clinical status, until the ambulance arrives", and that "[u]nstable patients should never be left alone". RN C did not request an ambulance for Mrs A, and did not monitor Mrs A, undertake observations, or offer any further assistance to Mrs A until the ambulance arrived.

54. I accept RN Carey's advice that RN C did not facilitate the safe transfer of Mrs A from the clinic to hospital. RN C should have contacted the ambulance for Mrs A, or ensured that one was contacted by the receptionist, and should have ensured that Mrs A was monitored adequately until the ambulance arrived. In light of Mrs A's presentation, it was inappropriate for RN C to leave Mrs A without medical oversight while she waited for the arrival of the ambulance.

55. By failing to facilitate the safe transfer of Mrs A from the clinic to hospital, RN C failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

56. For completeness, I note that RN C's submission that the ambulance may have taken slightly longer to arrive, had she followed the proper process, is speculative and has no bearing on RN C's responsibility to provide Mrs A with an appropriate standard of care following her presentation to the clinic. I also acknowledge that RN Carey advised that the ambulance service's response with regard to prioritising patients is reasonable in the context as described, although in this case there is no evidence that another person was presenting with the same acuity as Mrs A at the relevant time.

Handover to the ambulance service — Adverse comment

57. Ms D told HDC that when the ambulance arrived for Mrs A, ambulance staff entered the clinic looking for her. Ms D told HDC: "We were all confused about who called the ambulance." According to the clinic's Ambulance Transfer policy, on arrival of an ambulance, clinic staff are expected to provide handover of the patient to the ambulance service. Furthermore, RN Carey advised:

> "The safe transfer of patient care from one practitioner/service to another requires effective communication of relevant information. This includes assessed condition, clinical observations, response to administered treatments etc."

58. Having failed to arrange ambulance transfer for Mrs A, and subsequently monitor or undertake observations of Mrs A, RN C was unable to provide handover of Mrs A's care to the ambulance service in accordance with the clinic's policy, including providing information about Mrs A's condition since arriving at the clinic.

Enquiries — Other comment

59. Ms B told HDC that RN C asked whether her mother had New Zealand residency, to which Ms B responded that she did. Ms B told HDC that she "sensed some racism" in how she and her mother were treated in being asked about her mother's residency status. RN C told HDC that she would have requested this information from Ms B because transfer of non-residents by ambulance can cost "upwards of $660". RN C stated:

> "I assure [Ms B] that any interaction I had with her was not in any way motivated by her ethnicity …"

60. The clinic confirmed that patients are asked about residency status so that the clinic staff can advise patients of any additional cost they might incur.

61. I appreciate that in the circumstances of these events, being questioned about her mother's residency caused Ms B offence. However, having considered the responses from RN C and the clinic, I am satisfied that RN C had a reasonable basis for asking Ms B about her mother's residency status.

62. I consider that in future RN C should be mindful of carefully explaining the purpose of any information she is requesting from patients.

Opinion: The clinic — No breach

63. The clinic had a duty to Mrs A to ensure that services were provided that complied with the Code. In addition, under section 72(2) of the Health and Disability Commissioner Act 1994, an employing authority may be vicariously liable for acts or omissions by an employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

64. This Office has previously found providers not liable for the acts or omissions of staff, when those acts or omissions clearly relate to an individual clinical failure made by the staff member.[7]

65. At the time of these events, the clinic had specific written policies with regard to "Triage Management" and "Ambulance Transfer". RN Carey advised that the relevant policies at the clinic are:

> "… appropriate and reflect the relevant professional and legislative requirements. I agree with [the clinic] that it has appropriate policies in place to manage a presentation such as [Mrs A] and did so in November 2013. I consider that had [RN C] followed the relevant policy, nursing care commensurate with expectations would have been provided to [Mrs A] …"

[7] Opinion 12HDC01483 (12 July 2013) available at: www.hdc.org.nz.

66. RN Carey further advised that the newly implemented policies at the clinic are "clinically adequate". I agree with RN Carey's advice, and consider that the clinic took steps that were reasonably practicable to prevent acts or omissions such as RN C's in this event. Accordingly, I do not consider that the clinic is directly or vicariously liable for RN C's breaches of the Code.

Recommendations

67. I recommend that RN C:

a) Apologise to Mrs A. RN C's apology should be sent to this Office within **four weeks** of the date of this report, for forwarding to Mrs A.

b) Undertake training with regard to effective communication with consumers, in conjunction with the Nursing Council of New Zealand, within **three months** of the date of this report.

c) Report to HDC regarding the outcome of the above training, as well as on her failings in this case, and the changes she has made to her practice as a result of this case. This report is to be provided to HDC within **4 months** of the date of this report.

Follow-up actions

a) A copy of this report with details identifying the parties removed, except the name of the expert who advised on this case, will be sent to the Nursing Council of New Zealand, with a recommendation that it undertake a competence review of RN C.

b) A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, and it will be advised of RN C's name.

c) A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following expert advice was provided by Registered Nurse Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her mother [Mrs A], by [RN C] on 12 November, 2013. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the available documentation on file: complaint from [Ms B]; responses from the clinic including statement from [RN C], statement from [Ms D] (Receptionist), meeting minutes from 12 February 2014, Sections of [the clinic's] Company Manual (s3.20, s3.26, s3.3, s. 4.6, s5.7, s6.1); [Mrs A's] relevant clinical notes from [the public hospital] including the ambulance service patient report Form (PRF) and [the private hospital's] discharge summary; statement from [the private hospital's] CEO including patient information pamphlet 'Going home after surgery'; clinical advice from Dr D Maplesden.

3. The background to this complaint, sequence of events and differing recollections are comprehensively presented in the memo seeking my clinical advice. I have reviewed this information and confirm that it is supported by the information on file. With the purpose of brevity I have chosen not to repeat these sections in this advice.

4. I have been asked to provide advice concerning the appropriateness of the nursing advice provided by [RN C] to [Ms B], when she presented with her mother to [the clinic] on 12 November 2013. As there are discrepancies in the recollections of the events I have been asked to consider three scenarios:

   a. [Ms B's] recollections of events
   b. [RN C's] recollections of events
   c. [Ms D's] recollections of events

   I have also been asked to review the submitted [clinic] policies and provide comment concerning their appropriateness.

5. Provider response(s)
   [The clinic] advise[s] that in response to receiving notification of [Ms B's] complaint, they completed an in-depth internal review by senior management. The review showed that the policies and procedures for the management of such patient presentations were appropriate but were not followed in this instance. It reports that the requirement to assess and stabilise potential high acuity patients and then arrange for their transfer by ambulance to hospital. The response acknowledges that an appropriate standard of care was not provided to [Mrs A] and unreservedly apologises for this. Whilst

acknowledging that the decision making in this instance was not indicative of [RN C's] usual standard of competence or performance as a nurse, a disciplinary process has been conducted by [clinic] management. [The clinic] believe[s] that [RN C] has learned from this adverse event and is unlikely to repeat such an error in future. [RN C] also apologises and has offered to convey her apologies in person. In order to prevent any future reoccurrence of this type, [the clinic] have also ensured that all its staff members are cognisant of the relevant policies and clinic expectations.

6. Comments
   - Registered nurses accept responsibility for ensuring that their nursing practice and conduct meet the standards of professional, ethical and relevant legislative requirements such as NCNZ competencies[1,2] and Health and Disability Service Standards.[3] NCNZ also holds registered nurses accountable for ensuring that all health services that they provide are consistent with their education and assessed competencies. Accurate assessment and evaluation of clinical findings are integral parts of the nursing process.
   - All the relevant parties agree that [Mrs A] presented with a history of bleeding. In my opinion, the evaluation of such a symptom and its effect on a patient's haemodynamic status requires the checking of vital signs. I am critical that this was not done.
   - The safe transfer of patient care from one practitioner/service to another requires effective communication of relevant information. This includes assessed condition, clinical observations, response to administered treatments etc. Expectations for communication and interdisciplinary collaboration are framed by principles 3 and 6 as set by NCNZ.[4] In practice this requires communicating the nursing assessment and plan of care to the patient and family, and other relevant health practitioners.

7. Additional comments relating to [RN C's] response
   - I note that the response from [RN C] is dated 16 April 2014, which is post [the clinic's] review and subsequent interview. [RN C's] response states *…As one of the nurses rostered on that night I can accept that this may well have been me…* The ambiguity in this statement differs with the [the clinic] meeting documentation, which reports that following a review of CCTV, [RN C] was identified as the RN in question.
   - *…A call from the patient directly rather than from us would achieve a priority response from the ambulance service, who would get [Mrs A] to hospital sooner than if she was triaged and then formally transferred from the clinic…* I find this statement worrisome and would recommend that this is clarified with [the clinic] and the ambulance service if necessary.

[1] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[2] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).
[3] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).
[4] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).

8. Clinical advice

Following a review of the submitted documentation I am of the opinion, that the differing recollections — scenario a, b, c — do not alter the extent to which [RN C's] advice and practice departed from expected standards of nursing care. I am critical of [RN C's]

— failure to appropriately assess [Mrs A]
— failure to institute procedures for [Mrs A] to receive the necessary level of care
— failure to facilitate the safe transfer of [Mrs A] from [the clinic] to [the public hospital]

In my opinion, the nursing care provided by [RN C] to [Mrs A] was a severe departure from expected standards of nursing care in relation to assessment, monitoring and safe transfer of patient care.

In my opinion, the submitted policies — [the clinic's] Company Manual — are appropriate and reflect the relevant professional and legislative requirements. I agree with [the clinic's] response that it has appropriate policies in place to manage a presentation such as [Mrs A] and did so in November 2013. I consider that had [RN C] followed the relevant policy, nursing care commensurate with expectations would have been provided to [Mrs A] and her daughter, [Ms B].

Dawn Carey (RN PG Dip)

Nursing Advisor

Health and Disability Commissioner

Auckland